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DATE NOTICE SENT TO ALL PARTIES: Jun/24/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: power wheelchair purchase

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for power wheelchair purchase is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is X/XX/XX. She was helping a XX and hurt her back. She underwent spinal cord stimulator implantation and morphine pain pump in XXXX. Note dated X/XX/XX indicates that the patient presents for intrathecal pump decrease. Physical therapy note dated X/XX/XX indicates that the patient had an initial back injury at work in XX/XX. Following this injury she began taking Toradol for pain management and this led to vasculitis and Stevens-Johnson Syndrome requiring hospitalization for 5 months. She has not been able to stand or ambulate since then. The patient has been using a power wheelchair since XXXX. She has had her current power wheelchair for 3 years. She is unable to propel a manual wheelchair due to severe shoulder pain, neck pain and poor trunk control. Letter dated X/XX/XX indicates diagnoses are lumbar sprain, neuropathy, chronic pain and abnormality of gait. The patient is reportedly unable to stand and is non-ambulatory. She is unable to propel any type of manual wheelchair and is dependent upon a power wheelchair for all functional mobility and positioning/weight shifts. She is currently using a Group 3 Invacare TDX 5P power wheelchair. She complains of severe pain and discomfort with her positioning in this wheelchair and reports that the power seat functions on this power wheelchair work intermittently. She reports that several attempts to repair it have been unsuccessful. Therefore, she is wanting a new power wheelchair that fits her properly and operates dependably. Invoice dated X/XX/XX indicates the cost of the wheelchair being requested is $56,936.00. Follow up note dated X/XX/XX indicates that primary complaint is low back pain. The patient was last seen on X/X/XX with 17% decrease to the IT pump.

The initial request for power wheelchair purchase was non-certified on X/XX/XX noting that it appears the issues noted with the current wheelchair she is using over the last 4 years are subjective. It is not clear that she has a change in condition or worsening symptoms that would require a new chair. The proposed power chair appears to be the same type or group of chair. It is not stated that she could not have adjustments or repairs made to the current chair to provide for her medical needs. She is noted to have a caregiver for 8 hours a day M-F to assist with dressing, showering, grooming, cooking, house cleaning, driving, shopping

and positioning. She also has a manual wheelchair, shower chair, GBs, 4WW, and an adapted van with ramp. Her complaints of severe pain and discomfort with positioning do not appear to have been addressed professionally. There does not appear to be a question of needing a mobility device but of whether the current chair can be repaired and adjusted to meet the needs of the injured worker. Also, there are no competitive bids for repair or replacement. The denial was upheld on appeal dated X/X/XX noting that there was still no documented evidence of competitive bids for repair or replacement. As such, the request is not supported.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in X/XXX and has been using a power wheelchair since XXXX. She has had her current power wheelchair for 3-4 years. Letter dated X/XX/XX indicates she is currently using a Group 3 Invacare TDX 5P power wheelchair. She complains of severe pain and discomfort with her positioning in this wheelchair and reports that the power seat functions on this power wheelchair work intermittently. She reports that several attempts to repair it have been unsuccessful. Therefore, she is wanting a new power wheelchair that fits her properly and operates dependably. However, there is no documentation submitted for review to establish that the current chair is irreparable. There are no competitive bids for repair or replacement submitted for review. As such, it is the opinion of the reviewer that the request for power wheelchair purchase is not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)